



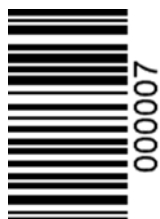
PENSION LIFE COVER FOR PERSONAL PENSIONS

APPLICATION DETAILS - BROKERAGE

Before you give us your personal information please note that Irish Life has a Data Privacy Notice. This explains what your data protection rights are and how and why we use your personal information. This is always available on our website at www.irishlife.ie or you can ask us for a copy.

PLEASE READ THE QUESTIONS CAREFULLY BEFORE ANSWERING THEM AND USE BLOCK CAPITALS.

If any item is blank or illegible, this will cause a delay in processing your application.



All customers are asked to fill in the eligibility and personal details sections.

Financial Adviser Details

[illegible]Financial Adviser Code

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If your Financial Broker or Adviser submits your application electronically Irish Life will only receive a copy of the Declarations section of this form. The original application form will be retained by your Financial Broker or Adviser and not checked by Irish Life.

Eligibility

1. Are you self-employed or a partner acting in some trade, profession or occupation? Yes ☐ No ☐
 2. Are you an employed person or the holder of an office of employment? Yes ☐ No ☐
If so, is one or more of your occupations non-pensionable? Yes ☐ No ☐
 3. Are you an Irish resident for tax purposes? Yes ☐ No ☐
 4. Please give policy numbers of any existing retirement contracts with Irish Life

1. Personal Details

Title (Mr/Mrs/Ms etc)

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[illegible]

Surname

Date of Birth (dd/mm/yyyy) / Age Next Birthday

Gender ☐ Male ☐ Female

Relationship Status Single ☐ Married ☐ Registered Civil Partner ☐

Separated ☐ Divorced ☐ Widowed ☐

[illegible]

During the last 12 months, which of the following best describes your smoking habits:

Smoker ☐ Occasional smoker ☐ Used nicotine replacement products or E-cigarettes ☐ Non Smoker ☐

[illegible][illegible]Chosen Retirement Age

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Level of Earnings	€	each year
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A Non-smoker has not smoked or used any nicotine replacement products or E-cigarettes in the last 12 months

We need this information
to ensure that the level
of cover suits your
circumstances

[illegible][illegible][illegible][illegible]

At any time up to the end of the term, you have the option to convert to another life cover plan. The exact definition and terms available in the policy document. The option of Guaranteed Life Cover again only applies to a maximum Life Cover of €1 million. These limits are in respect of the total cover converted across all policies belonging to the life assured.

Are you or any of the Beneficiaries, Trustees, Settlor, Appointers or in the case of a Company Owner, Director, Beneficial Owner (or have been within the last 12 months), a PEP or RCA ? Yes ☐ No ☐

Amount of Life Cover you want €

Age at which cover should cease	
18	
20	
22	
24	
26	
28	
30	
32	
34	
36	
38	
40	
42	
44	
46	
48	
50	
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72	
74	
76	
78	
80	
82	
84	
86	
88	
90	
92	
94	
96	
98	
100	

Do you want inflation protection? Yes ☐ No ☐

Do you want Guaranteed Cover again (convertible option)? Yes ☐ No ☐

Is the cover to start immediately? (If not please let us know later when you want cover to start)

Premium amount	€
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Frequency of Direct Debit Every Month ☐ Every 3 Months ☐ Every 6 Months ☐ Every Year ☐

1st to 28th of month > What date of the month do you want your Direct Debit taken?

Cheques for regular contributions can only be made when contributions are made on a yearly basis and exceed €600

Do you want your cover to begin immediately, if accepted? Yes ☐ No ☐

How would you like to receive your plan communications from us? (for example, your welcome pack, letters and regular statements). Please tick one option:

☐ Online ☐ By Paper Post

Plan Schedule by post everything else electronically Yes ☐ No ☐

Do you want the original plan schedule to be sent to your financial adviser?
(not applicable if plan is taken out through an Irish Life tied channel) Yes ☐ No ☐

Is the plan being set up under a conversion of an existing Irish Life Plan? Yes ☐ No ☐

If NO we will contact
your financial adviser for
confirmation of the start date

If you do not choose an option we will assume you want to receive communications by paper post. Your Plan communication will be securely stored in your personal online account at www.irishlife.ie. You will be notified by text and email when communications are added to your account.



UNDERWRITING QUESTIONS

PLEASE READ THE QUESTIONS CAREFULLY BEFORE ANSWERING THEM AND USE BLOCK CAPITALS.

If any item is blank or illegible, this will cause a delay in processing your application.

Medical and Other Information

Your personal health information:

In addition to our Irish Life Data Privacy Notice, the following is more detail relating to your personal health information that we collect and use in connection with this plan contract.

We need your relevant personal information and personal health information for underwriting decisions. This will determine whether we can offer cover and on what terms. We also need your relevant personal information and personal health information to assess and pay claims. If relevant, we will share your personal health information with reinsurers for underwriting and claims decisions. We can use your personal information and personal health information for any subsequent applications to Irish Life.

In addition to the personal health information we collect from you, we will request and receive your relevant personal health information from GPs, consultants, hospitals or other health professionals, and share your relevant personal health information with GPs, consultants, hospitals or other health professionals, if needed.

Material Facts:

You must tell us all relevant information when answering all of the questions. If you do not, or if any answers are not true and complete, we could treat the plan as void. This includes disclosing tobacco consumption or use of nicotine replacement products including e-cigarettes. If you fail to reveal all material facts there will be no cover under the plan, we will not refund the payments and we will not pay a claim.

A material fact (relevant information) includes anything that would likely influence the assessment and acceptance of an application for insurance. If you are not sure whether something is relevant, you should tell us anyway. If there is anything not covered by the questions on this form that you think we should know, please tell us in the section 'Other medical evidence'. We may also contact you if we need to ask you for further information on your answers or as part of any subsequent claim. We will rely on what you tell us and we will not automatically clarify or confirm any information you provide.

You can address any highly confidential information to Irish Life's Underwriting Team in a sealed envelope with your name, date of birth and application number (if applicable). You must refer to this information when answering your health questions.

If your health, circumstances, or answers to any of the questions in this application form change between the date you apply for cover and the date your application is accepted, you must let us know immediately as failure to do this may result in a claim being refused.

Genetic Test Information:

You should not tell us about any genetic test (that is, any analysis of chromosomes, DNA or RNA to detect genetic abnormalities in individuals) which you may have had. You must however, tell us if you are having treatment for, or experiencing symptoms of, a genetic condition. You will be asked for full information about your family history, including all genetic conditions.

Consent to Automated Decisions, including Profiling:

I agree to automated underwriting decisions being made about me based on set risk criteria and using my personal information, including personal health information. I understand this will make my application process quicker and that the automation is designed to reduce costs, improve efficiency, quality and consistency in underwriting decisions. I understand that I have the right to withdraw consent at any time by emailing dataprotectionqueries@irishlife.ie or writing to Irish Life Data Protection Team. I also understand that I have the right to object and to request that a person review and make the final underwriting decision.

Life Assured 1

I agree ☐

I don't agree ☐

Life Assured 2

I agree ☐

I don't agree ☐

Medical and Other Information (continued)...

	First Person	Second Person
(1). Please give the name and address of your doctor.	<input type="text"/>	<input type="text"/>
If you have changed doctor in the last year, please give the name and address of your previous doctor as well.	<input type="text"/>	<input type="text"/>

	First Person	Second Person
(2). Please give your height and weight	<input type="text"/> Feet <input type="text"/> Inches <input type="text"/> Stones <input type="text"/> lbs OR <input type="text"/> Cms <input type="text"/> Kg	<input type="text"/> Feet <input type="text"/> Inches <input type="text"/> Stones <input type="text"/> lbs OR <input type="text"/> Cms <input type="text"/> Kg

	First Person	Second Person
(3). Which of the following best describes your smoking habits:		
I am a smoker	<input type="radio"/>	<input type="radio"/>
I am an occasional smoker or have smoked in the last 12 months	<input type="radio"/>	<input type="radio"/>
I have used nicotine replacement products including E-cigarettes in the last 12 months	<input type="radio"/>	<input type="radio"/>
I have not smoked or used nicotine replacement products including E-cigarettes in the last 12 months	<input type="radio"/>	<input type="radio"/>
I am a life long non smoker	<input type="radio"/>	<input type="radio"/>
If selected 'I am a smoker': What do you smoke and how many/much a day?		
Cigarettes	<input type="radio"/> number <input type="text"/> per day	Cigarettes <input type="radio"/> number <input type="text"/> per day
Cigars	<input type="radio"/> <input type="text"/> per day	Cigars <input type="radio"/> <input type="text"/> per day
Pipe	<input type="radio"/> <input type="text"/> per day	Pipe <input type="radio"/> <input type="text"/> per day

(4). Typically, how many alcoholic drinks do you consume in a week?	None <input type="radio"/>	None <input type="radio"/>
	1 - 10 <input type="radio"/>	1 - 10 <input type="radio"/>
	11 - 20 <input type="radio"/>	11 - 20 <input type="radio"/>
	20 - 40 <input type="radio"/>	20 - 40 <input type="radio"/>
	40 - 60 <input type="radio"/>	40 - 60 <input type="radio"/>
	Over 60 <input type="radio"/>	Over 60 <input type="radio"/>

(5). Have you ever had treatment or advice from a health professional in relation to stopping or reducing your alcohol consumption?

Yes ☐ No ☐ Yes ☐ No ☐

(6). Have you ever had diabetes (type 1 or 2 or pregnancy related) or sugar in the urine?

Yes ☐ No ☐ Yes ☐ No ☐

Please specify what do you smoke and how many / much a day below

A Non-smoker has not smoked or used any nicotine replacement products or E-cigarettes in the last 12 months

It is our practice to carry out occasional tests to confirm smoker status

One alcoholic drink is: a pint of beer, a glass of wine or one measure of spirits.

Diabetes includes Type 2 diabetes treated by diet, gestational diabetes or Sugar in urine

Medical and Other Information (continued)...

	First Person		Second Person	
(7). Have you ever had any disease or disorder of the heart, including angina, heart attack, bypass, cardiomyopathy, heart valve disorder or heart murmur?	Yes <input type="radio"/>	No <input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
(8). Have you ever had a stroke, brain haemorrhage or brain injury, transient ischaemic attack(TIA), aneurysm, or any disease of the arteries or veins, including poor circulation in the legs?	Yes <input type="radio"/>	No <input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
(9). Have you ever had treatment or advice for any form of cancer or malignant condition, leukaemia, Hodgkins disease, lymphoma, melanoma, or a benign brain or spinal tumour?	Yes <input type="radio"/>	No <input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
(10). Have you ever had symptoms of or had treatment for epilepsy (including seizures, fits or blackouts), multiple sclerosis, optic neuritis, paralysis or any neurological condition?	Yes <input type="radio"/>	No <input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
(11). Have you ever had symptoms of, treatment or investigations for trembling, numbness, loss of feeling or tingling in face, hands or feet or temporary loss of muscle power?	Yes <input type="radio"/>	No <input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
(12). Have you ever had symptoms of or treatment for any disorder of the stomach, liver, pancreas or bowel (including Crohn's disease, ulcerative colitis, polyps or ulcer)?	Yes <input type="radio"/>	No <input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
(13). Have you ever had symptoms, treatment or advice for or been referred for any mental health problems including depression, self harm or psychiatric disorders including bipolar, mood or eating disorders?	Yes <input type="radio"/>	No <input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
(14). Have you ever taken drugs for other than medicinal purposes, including the use of recreational drugs?	Yes <input type="radio"/>	No <input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
(15). Have you ever tested positive for Hepatitis B or Hepatitis C, HIV or are you waiting for the results of such tests?	Yes <input type="radio"/>	No <input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
(16). Are you currently taking or have you been advised to take prescribed drugs, medicines or tablets, creams, inhalers, drops or sprays or have you taken such a course lasting more than two weeks within the past year?	Yes <input type="radio"/>	No <input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
(17). Within the past five years have you been diagnosed with or had treatment for high blood pressure, high cholesterol, chest pains, an irregular heart beat or any blood disorder including haemochromatosis or anaemia?	Yes <input type="radio"/>	No <input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
(18). Within the past five years have you had symptoms or had treatment for asthma, bronchitis, sarcoidosis, emphysema or any other disorder of the lungs or airways?	Yes <input type="radio"/>	No <input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
(19). Within the past five years have you noticed or had symptoms, treatment or advice for any cyst or lump including breast lump or cyst, an abnormal cervical smear, an abnormal mole or a growth whether seen by a doctor or not?	Yes <input type="radio"/>	No <input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
(20). Within the past five years have you had symptoms of or treatment for any kidney, bladder, urinary disorder (including blood/protein in urine) or prostate disorder (including raised PSA level)?	Yes <input type="radio"/>	No <input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>
(21). Within the past five years have you had any symptoms of or treatment for any disorder of eyes (including any visual disturbance of the eyes, such as double vision or blurred vision) or the ears (including hearing impairment or loss of balance)?	Yes <input type="radio"/>	No <input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>

Vision corrected by lens can be omitted

Medical and Other Information (continued)...

First Person

Second Person

(22). Within the past five years have you had any symptoms of, or required treatment for:

- any back or neck pain including sciatica, trapped nerves or whiplash
- any joint pain or disorder of the knees, hips, ankles, shoulders, elbows or wrists
- any type of arthritis or gout
- any muscular pains, cartilage, ligament or tendon injuries?

Yes ☐ No ☐

Yes ☐ No ☐

(23). Within the past five years have you had any symptoms, treatment or advice for stress, anxiety, low mood, chronic fatigue or fibromyalgia?

Yes ☐ No ☐

Yes ☐ No ☐

(24). Within the past five years, have you seen or been advised to see any specialist as an in-patient or out-patient at any hospital or clinic for any other illness or condition not already mentioned?

Yes ☐ No ☐

Yes ☐ No ☐

(25). Within the past five years have you undergone or been advised to undergo any medical investigation including blood test, scan, imaging and x-ray or to have a surgical operation?

Yes ☐ No ☐

Yes ☐ No ☐

(26). Within the past three years have you been unable to work for more than four consecutive weeks at a time?

Yes ☐ No ☐

Yes ☐ No ☐

(27). Do you take part in or have any intention of taking part in any kind of hazardous leisure activity (including private flying, motor sports, mountaineering or scuba diving etc)?

Yes ☐ No ☐

Yes ☐ No ☐

(28). Have you any intention of living or travelling outside of the EU, other than for holidays of less than 8 weeks duration, or have you resided out of the EU, North America, Australia or New Zealand for longer than one year in the last 10 years?

Yes ☐ No ☐

Yes ☐ No ☐

(29). Have you ever been offered special terms, postponed or declined for life cover, income protection or specified illness cover or have you made a claim for income protection or specified illness cover?

Yes ☐ No ☐

Yes ☐ No ☐

(30). Have any of your parents, brothers or sisters ever had any of the following conditions before age 60?

Yes ☐ No ☐

Yes ☐ No ☐

Angina - Heart Attack - Bypass surgery - Angioplasty - Cardiomyopathy - Stroke - Diabetes - Cancer (Bowel, Breast, Ovarian or other site) - Familial Polyposis of the Colon - Polycystic Kidneys - Multiple Sclerosis - Motor Neurone Disease - Parkinson's - Alzheimer's - Dementia - Muscular Dystrophy - Huntington's.

First Person

Second Person

	Condition Suffered	Age Started	Condition Suffered	Age Started
Father	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mother	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Brothers	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sisters	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Failure to disclose a family history could result in a potential claim being refused.

Medical Details – Other Medical Evidence

Is there any other medical evidence you would like to disclose in relation to the health questions above?

First Person

Question No

Second Person

Question No

Will there be a Fast Track Questionnaire or any other questionnaires accompanying the application form?

First Person

Yes ☐ No ☐

Second Person

Yes ☐ No ☐

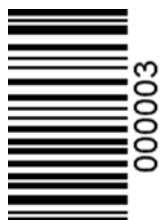
Information is correct as of 01/05/2018 and is subject to change.

Information is correct as of 01/05/2018 and is subject to change.



PENSION LIFE COVER FOR PERSONAL PENSION PLANS

DECLARATIONS

**Proposal Number:**

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Customer Review Number

[illegible]

Name Life Assured 1

[illegible]

Financial Adviser Name

[illegible]

If you submit this proposal electronically you should only send us this section.

Any words in the singular also mean the plural as applicable (e.g. "I" means "we" and "my" means "our" etc.)

A. Declaration under regulation 6(3) of the Life Assurance (Provision of Information) Regulations 2001

WARNING

If you propose to take out this plan in complete or partial replacement of an existing plan, please take special care to satisfy yourself that this plan meets your needs. In particular, please make sure you are aware of the financial consequences of replacing your existing plan. If you are in doubt about this, please contact your insurer or insurance adviser.

Please complete this section by ticking the appropriate box:

This includes:
Canada Life
Progressive Life

- Yes, this plan is replacing an Irish Life plan

C

Yes, this plan is replacing a plan from another life company

C

No, this plan is not replacing another plan

C

Existing Plan Number

Declaration of Insurer / Financial Adviser:

I hereby declare that in accordance with Regulation 6(1) of the Life Assurance (Provision of Information) Regulations, 2001,

Customer's name

[illegible]

Address

[illegible]

Address

[illegible]

has been provided with the information specified in Schedule 1 (Customer Information Notice) to those Regulations and that I have advised the customer as to the financial consequences of replacing an existing plan with this plan by cancellation or reduction, and of possible financial loss as a result of such replacement.



- Signature of Financial Adviser

Please sign and date

Date (dd/mm/yyyy)

		/		/				
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Declaration of Customer:

I confirm that I have received in writing the information specified in the above declaration.



Please sign and date

Signature of Customer

X

Date (dd/mm/yyyy)

		/			/				
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B. Plan Declaration

I understand and agree that my contract with Irish Life Assurance plc (Irish Life) will be based on the declarations in this form, my completed application form (online or otherwise), any supplementary questions answered, any statements made to Irish Life in writing or by telephone, any information I give to a medical examiner acting for Irish Life and all terms and conditions given to me by Irish Life. I understand that this contract shall not be capable of being surrendered, commuted or assigned except as provided under Chapter 2 of Part 30 of the Taxes Consolidation Act 1997.

I have read and understand the important information about my obligation to tell Irish Life about all material facts in connection with the application and I understand that if I do not tell Irish Life all material facts, this contract could be void. If this happens, I understand and acknowledge there will be no cover under the plan, Irish Life will not refund my premiums and Irish Life will not pay a claim.

I declare that all information, statements and answers I have provided, including those about tobacco consumption or use of nicotine replacement products including e-cigarettes, are true and complete.

I understand that I must tell Irish Life in writing about any changes in my health, circumstances, or answers to the questions in this application form change between the time I applied for cover and the date my application is accepted.

I understand that this plan will not start until Irish Life has accepted me for cover and I have paid the first payment. I acknowledge that a copy of my application will be sent to me and agree to notify Irish Life, in writing, if:

- I do not receive the printed record
- Any information in this record is, false, incorrect or incomplete

I understand that Irish Life can use my personal information for any subsequent applications to Irish Life.

I authorise Irish Life to request and receive my personal health information now (or as part of any claim assessment including after my death) from any health professional who at any time has attended me concerning my physical or mental health and to share my personal health information with any health professional for the purpose of processing my application and assessing claims.

- I confirm I have read and understood the Medical and Other Important Information section.
- I confirm I have received the product booklet and Customer Information Notice.
- I confirm I have been informed about the Irish Life Data Privacy Notice and where to get this.
- I confirm I have read and understood the Plan Declaration.



Please sign and date

Signature of Customer

X

Date (dd/mm/yyyy)

		/			/				
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C. Optional Consent

Consent to Sharing with Other Companies in the Irish Life Group

I agree to Irish Life Assurance sharing my personal information (excluding my personal health information) with other companies within the Irish Life Group, such as Irish Life Health. I understand this is to assist in developing combined customer services (for example, access to services from different Group companies on one online platform). This is an area that will continue to improve with a view to adding new customer engagement offerings.

You can change your mind at any time and opt-out of any further sharing by emailing dataprotectionqueries@irishlife.ie or writing to Irish Life Data Protection Team. If you opt-out we will keep a record of your instruction to opt-out.

Customer

I agree ☐

I don't agree ☐



